

Application for Adult Medical Assistance

This is an application for Medical Assistance services for adults age 19 years or older who are blind or disabled, as well as for adults who are 65 or older. If none of these conditions apply to you, please contact your local department of social services (DSS) to obtain the correct application.

Medical Assistance may help pay hospital bills, doctor's visits, and Medicare premiums. Answer all of the questions to the best of your ability. Please remember to give complete and accurate information. If there is missing information, we may not be able to determine your eligibility for medical assistance.

To apply for benefits, follow these steps:

- Step 1:** Complete this application. You can access an electronic version of this application at **www.dss.virginia.gov**. Read the instructions carefully and give accurate information.
- Step 2:** Sign and date your application. If you and your spouse are applying, you both need to sign the application. If you are applying for someone else, please answer the questions as they relate to that person and sign the application.
- Step 3:** Once you have completed your application mail, fax, or bring it to your local DSS office. If you need help completing your application or if you have questions, please contact your local DSS office. A list of addresses and phone numbers of the local departments is available at **www.dss.virginia.gov**. You do not need to have an interview with local agency staff.
- Step 4:** Provide verification(s) and information as requested by the DSS.

Frequently Asked Questions

How long does it take to get benefits?

It takes about 45 days to process most Medical Assistance applications. If a disability determination is needed, it may take as long as 90 days.

Being prepared helps the process move smoothly. For anyone applying for Medical Assistance, the following information may be needed:

- Proof of identity, such as: ID card, driver's license
- Proof of citizenship, such as: birth certificate, certificate of naturalization
- Social Security numbers of everyone requesting assistance
- Proof of income, such as: pay stubs, child support, and income award letters
- Proof of resources, such as: bank statements

If you need assistance in gathering this information, please tell your worker.

How do you use my personal information?

We will use your personal information to determine eligibility for Medical Assistance.

To verify the information you give us, we use the Income and Eligibility Verification System (IEVS) and the State Verification Exchange System (SVES). We also match your information against Federal, State, and local records, including the Virginia Employment Commission, the Department of Motor Vehicles, the Internal Revenue Service, U.S. Citizenship and Immigration Services (formerly the Immigration and Naturalization Service or INS), and the Social Security Administration.

Section 1. General Information

Would you like to name a person who could apply for Medical Assistance benefits or receive correspondence and notices for you? ☐ Yes ☐ No If yes, please provide the following information in the space provided below.

Name of Representative

Phone Number

Address (Street, P.O. Box, etc.)

City, State, Zip

I want this representative to: ☐ Apply for and/or renew Medical Assistance
☐ Receive requests for information needed to determine eligibility
☐ Receive letters regarding actions taken on my case
☐ Other (specify): _____

Voter Registration Certification

As a citizen of the Commonwealth of Virginia, we are required to provide you with the opportunity to register to vote when applying for benefits. Please check one of the following:

If you are not registered to vote where you live now, would like to register to vote today?

- ☐ Yes, I would like to register to vote. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to fill out your voter registration application form in private.)
- ☐ I do not want to apply to register to vote today.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount assistance or services that you will be provided by this agency. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

Secretary of the Virginia State Board of Elections
Ninth Street Office Building
200 North Ninth Street
Richmond, VA 23219-3497
Phone: (804) 786-6551

Agency Use Only: ☐ Face-to-face interview not required. A voter registration form was mailed.

Section 1. General Information

Tell us who is applying for Medical Assistance

If you are completing this application for someone else, answer the questions as they relate to that person.

1. Self		
Name	Relationship to You	Date of Birth
<hr/>		
Street Address (include apartment number)	Mailing Address (if different from your street address)	
<hr/>		
City	City	
<hr/>		
State, ZIP	State, ZIP	
<hr/>		
() -	() -	
Home Phone Number	Daytime or Message Phone Number	
<hr/>		
In what city or county do you live?		
<hr/>		

Social Security Number _____

Gender:

- ☐ Male
☐ Female

Marital Status:

- ☐ Married
☐ Never Married
☐ Divorced
☐ Widowed
☐ Separated

Virginia Resident:

- ☐ Yes
☐ No

Place of Birth (City, State, Country)

U.S. Citizen? ☐ Yes ☐ No

— If you are not a U.S. Citizen, please provide the following information:

Alien Registration Number

Date started living in the U.S.

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity:

- ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Racial Heritage:

- ☐ White ☐ Black or African American
☐ Asian ☐ Native Hawaiian/Other Pacific Islander
☐ Other ☐ American Indian/Alaskan Native

Name of Tribe: _____

What is the primary language spoken in your household?

- | | | | | | |
|----------------------------------|---|----------------------------------|---|-----------------------------------|------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Laotian | <input type="checkbox"/> Somali | <input type="checkbox"/> French | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> Chinese | <input type="checkbox"/> Kurdish | <input type="checkbox"/> German | <input type="checkbox"/> Japanese | <input type="checkbox"/> Cambodian |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Haitian-Creole | <input type="checkbox"/> Arabic | <input type="checkbox"/> Other (specify): _____ | | |

Section 2. Household Information

Tell us about your spouse and about children under 21 years of age who live with you

2.

Name	Relationship to You	Date of Birth
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Assistance Requested: <input type="checkbox"/> Medical Assistance <input type="checkbox"/> None
		Virginia Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No
If the person listed in #2 above is not applying for medical assistance, you are not required to provide the information below.		
Social Security Number: _____		
Place of Birth: _____ (City, State, Country)		
U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
— If not a U.S. Citizen, please provide the following information:		
Alien Registration Number		Date Started Living in the U.S.

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity:
☐ Hispanic/Latino ☐ Not Hispanic/Latino

Racial Heritage:
☐ White ☐ Black or African American
☐ Asian ☐ Native Hawaiian/Other Pacific Islander
☐ Other ☐ American Indian/Alaskan Native

Name of Tribe: _____

3.

Name	Relationship to You	Date of Birth
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Assistance Requested: <input type="checkbox"/> Medical Assistance <input type="checkbox"/> None
		Virginia Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No
If the person listed in #3 above is not applying for medical assistance, you are not required to provide the information below.		
Social Security Number: _____		
Place of Birth: _____ (City, State, Country)		
U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
— If not a U.S. Citizen, please provide the following information:		
Alien Registration Number		Date started living in the U.S.

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity:
☐ Hispanic/Latino ☐ Not Hispanic/Latino

Racial Heritage:
☐ White ☐ Black or African American
☐ Asian ☐ Native Hawaiian/Other Pacific Islander
☐ Other ☐ American Indian/Alaskan Native

Name of Tribe: _____

If additional space is needed to add other family members please ask for an additional application form.

Section 2. Household Information

Please answer these questions for anyone who is applying for Medical Assistance

1. Has anyone in your household ever applied for or received any Medical Assistance from a social service agency in another state or Virginia city or county? ☐ Yes ☐ No
— If **yes**, please indicate which state or Virginia city or county below:

2. Is anyone in your household temporarily away from home? ☐ Yes ☐ No
— If **yes**, please provide the following information:

Name

Date Left

Reason for Leaving

Expected Return Date

3. Has anyone in your household ever been determined to be disabled by the Social Security Administration? ☐ Yes ☐ No — If **yes**, please provide the name of the individual:

Name

Name

4. Did anyone applying for Medical Assistance receive a medical service during the last 3 months? ☐ Yes ☐ No
— If **yes**, for which months: _____

Complete questions 5-9 if a disability determination is needed for anyone applying for Medical Assistance.

5. Have you or anyone for whom you are applying ever applied for Social Security, Supplemental Security Income (SSI) or Railroad Retirement benefits as a disabled person? ☐ Yes ☐ No
— If **yes**, please provide the name of the persons and date of application:

Name of Person and Date of Application

Name of Person and Date of Application

6. If the application for Social Security, Supplemental Security Income (SSI) or Railroad Retirement benefits was denied, did you file an appeal of the denial? ☐ Yes ☐ No
— If **yes**, please tell us the outcome of the appeal.

Section 2. Household Information

7. Has it been less than 12 months since the most recent application for Social Security, Supplemental Security Income (SSI) or Railroad Retirement benefits was denied? ☐ Yes ☐ No

8. Do you or your spouse have a new medical condition or has the condition changed or worsened since the most recent application for disability was denied? ☐ Yes ☐ No

9. Have you or your spouse ever received Supplemental Security Income (SSI)? ☐ Yes ☐ No

Has the SSI payment stopped? ☐ Yes ☐ No

—If **yes**, explain whose payment stopped, when it stopped, and why it stopped.

Section 3. Long-term Care

Please answer questions 10 thru 13 if you are applying for anyone who is in a nursing facility or assisted living facility, or who requires nursing home care or assistance to remain in the home.

10. Do you or your spouse need nursing facility care or help such as bathing, dressing, toileting, etc., so that you can remain in your own home? ☐ Yes ☐ No

—If **yes**, and there is a spouse who lives somewhere else, what is the name and address of the spouse?

(Note: Under Virginia law persons are considered married and legally responsible for each other until they divorce.)

11. Do you or your spouse live in one of the following:

☐ Assisted Living Facility (ALF) ☐ Nursing Facility ☐ Group Home ☐ Hospital or other Medical Facility

— If you checked one of the above, please provide the following information:

Name

Date of Entry

In What County Was the Prior Address?

Person's address prior to entering the facility

Facility Name

Facility Address

Was placement made by a State agency? ☐ Yes ☐ No

Section 3. Long-term Care

12. Does the individual in the nursing facility or requiring assistance in the home have long-term care insurance? ☐ Yes ☐ No — If **yes**, please provide the following information:

Name of Insurance Company

Address

City, State, ZIP

Policy Number

Person(s) Insured

Is this a Partnership Policy? ☐ Yes ☐ No

13. Have you or your spouse sold, transferred, placed in a trust/annuity, or given away any resources, such as your home or other real property, cash, bank accounts, or cars in the last sixty (60) months (5 years)?
☐ Yes ☐ No — If **yes**, please provide the following information:

Type of Property Transferred

\$ Value at Transfer

\$ Amount Received

Date of Transfer

From Whom

To Whom

Explain the Reason for Transfer

Note: If more than one transfer has occurred, please attach documentation.

Section 4. Resources and Assets

14. Do you or your spouse have any money/cash on hand that is not in a bank? ☐ Yes ☐ No
— If **yes**, please provide the following information:

Name

\$ Amount

Name

\$ Amount

15. Do you or your spouse have any of the following resources? ☐ Yes ☐ No
— If **yes**, please check the boxes that apply and provide the information requested below:

☐ Checking, Savings
☐ Credit Union

☐ Deferred Compensation Plan
☐ Certificate of Deposit (CD)

☐ Christmas Club
☐ Money Market Funds

1.

Owner Name

Co-Owner Name

Name of Bank

Account Type

Account Number

\$ Balance/Value

Section 4. Resources and Assets

2.

Owner Name

Co-Owner Name

Name of Bank

Account Type

Account Number

\$

Balance/Value

3.

Owner Name

Co-Owner Name

Name of Bank

Account Type

Account Number

\$

Balance/Value

16. Do you or your spouse have any stocks or bonds, trust funds, pension plans, retirement accounts, trusts, annuities, promissory notes, or deeds of trust? ☐ Yes ☐ No

— If **yes**, please provide the following information:

1.

Owner Name

Co-Owner Name

Where is the Account Held?

Account Type

Account Number

\$

Balance/Value

2.

Owner Name

Co-Owner Name

Where is the Account Held?

Account Type

Account Number

\$

Balance/Value

3.

Owner Name

Co-Owner Name

Where is the Account Held?

Account Type

Account Number

\$

Balance/Value

17. Do you or your spouse have any life insurance? ☐ Yes ☐ No

— If **yes**, please provide the following information:

1.

Owner Name

Person Insured

Type of Insurance (whole life or term)

Company Name

Policy Number

\$

Face Value

\$

Cash Value

Section 4. Resources and Assets

2.

Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	\$ Face Value	\$ Cash Value

3.

Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	\$ Face Value	\$ Cash Value

18. Do you or your spouse have burial plots, burial arrangements, or trust funds for burial? ☐ Yes ☐ No
— If yes, please provide the following information:

Owner(s)	Item/Type	\$ Value/Amount Owed
Owner(s)	Item/Type	\$ Value/Amount Owed
Owner(s)	Item/Type	\$ Value/Amount Owed

19. Do you or your spouse have real property, including home property, life rights/estates, land, buildings, or mobile homes? ☐ Yes ☐ No — If yes, please provide the following information:

Owner(s)	Type of Property/Number of Acres	\$ Value/Amount Owed
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Do you receive money from this property? ☐ Yes ☐ No Is this property rented? ☐ Yes ☐ No

Is this property currently for sale? ☐ Yes ☐ No

20. Do you or your spouse have any licensed or unlicensed cars, trucks, vans, boats, motor homes, recreational vehicles, utility trailers, motorcycles, or mopeds? ☐ Yes ☐ No
— If yes, please provide the following information:

Owner(s)	Year-Make-Model	\$ Value/Amount Owed
Owner(s)	Year-Make-Model	\$ Value/Amount Owed
Owner(s)	Year-Make-Model	\$ Value/Amount Owed

Section 4. Resources and Assets

21. Do you or your spouse have any property that is used in the operation of a business, such as farm equipment, tools, or livestock? ☐ Yes ☐ No

— If **yes**, please provide the following information:

Owner(s)	Type	\$ Value/Amount Owed
_____	_____	_____
Owner(s)	Type	\$ Value/Amount Owed
_____	_____	_____

22. Do you or your spouse expect a change in resources this month or next month? ☐ Yes ☐ No

— If **yes**, please explain below and give the date the change is expected:

Date Change Expected _____

Section 5. Income

23. Do you or your spouse receive any of the following types of money from working? ☐ Yes ☐ No

(Check all that apply and provide us with the requested information)

- | | | |
|---|--|---|
| <input type="checkbox"/> Wages/Salary | <input type="checkbox"/> Earned Sick Pay | <input type="checkbox"/> Other Self-employment |
| <input type="checkbox"/> Contract Income | <input type="checkbox"/> Vacation Pay | <input type="checkbox"/> Odd jobs |
| <input type="checkbox"/> Commissions, Bonuses, Tips | <input type="checkbox"/> Farming/Fishing | <input type="checkbox"/> Any other money from working |
| | <input type="checkbox"/> Babysitting/Daycare | |

Name	Employer Name, Address or Phone Number	
Type of Work	Gross Monthly Earnings	Pay Schedule <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other: _____ <input type="checkbox"/> Twice a Month
Next Pay Date		
Name	Employer Name and Address or Phone Number	
Type of Work	Gross Monthly Earnings	Pay Schedule <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other: _____ <input type="checkbox"/> Twice a Month
Next Pay Date		

Section 5. Income

24. Do you or your spouse expect to start working? ☐ Yes ☐ No

(This includes all jobs: full time, part time, seasonal, temporary, self-employment, etc.)

— If **yes**, please provide the following information:

Name	Employer	
\$		Pay Schedule
Anticipated Monthly Earnings	Date Job Will Start	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Biweekly <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Twice a Month
Employer Phone Number	First Pay Date	

25. Do you or your spouse receive or expect to receive any of the following income? ☐ Yes ☐ No

(Check all that apply and provide the information below.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Social Security/SSI | <input type="checkbox"/> Unemployment benefits | <input type="checkbox"/> Annuities |
| <input type="checkbox"/> Railroad Retirement | <input type="checkbox"/> Training allowances | <input type="checkbox"/> Interest, dividends |
| <input type="checkbox"/> Black Lung benefits | <input type="checkbox"/> Room/board income | <input type="checkbox"/> Strike benefits |
| <input type="checkbox"/> Military Allotment | <input type="checkbox"/> Workforce Investment Act | <input type="checkbox"/> Prize winnings |
| <input type="checkbox"/> VA benefits | <input type="checkbox"/> Child support, alimony | <input type="checkbox"/> Cash gifts or contributions |
| <input type="checkbox"/> Retirement Pension
(410K, IRA, Keogh) | <input type="checkbox"/> Rental Income | <input type="checkbox"/> Insurance settlement |
| <input type="checkbox"/> Public Assistance | <input type="checkbox"/> Loans | <input type="checkbox"/> Inheritance |
| <input type="checkbox"/> Worker Compensation | <input type="checkbox"/> Trusts | <input type="checkbox"/> Any other source of money |

List all income you or anyone in your household receives or expects to receive

1.	\$		
Name of Person	Income Amount	Type of Income	How Often Received?
2.	\$		
Name of Person	Income Amount	Type of Income	How Often Received?
3.	\$		
Name of Person	Income Amount	Type of Income	How Often Received?
4.	\$		
Name of Person	Income Amount	Type of Income	How Often Received?

26. Did you or your spouse lose employment or have income terminated in the past three months?

☐ Yes ☐ No

— If **yes**, please explain provide the following information:

Name	Type of Income	Last Date Received

Section 5. Income

27. Does anyone help you pay, or lend you money to pay rent, utilities, medical bills, or any other bills?

☐ Yes ☐ No

— If **yes**, please provide the following information:

Person Receiving Money

Person Providing Help

Type of Help Received

\$

Amount

Does the money come directly to you?

☐ Yes ☐ No

Is this a loan?

☐ Yes ☐ No

Is repayment expected?

☐ Yes ☐ No

Person Receiving Money

Person Providing Help

Type of Help Received

\$

Amount

Does the money come directly to you?

☐ Yes ☐ No

Is this a loan?

☐ Yes ☐ No

Is repayment expected?

☐ Yes ☐ No

28. Do you or your spouse expect any changes in the money you will receive within the next 60 days?

☐ Yes ☐ No

— If **yes**, please explain below and provide the date the change is expected:

Date Expected _____

Section 6. Medicare

29. Do you or your spouse have Medicare? ☐ Yes ☐ No

— If **yes**, please provide the following information:

1.

Policy Holder

Person Insured

Medicare ID Number

Begin Date

End Date

2.

Policy Holder

Person Insured

Medicare ID Number

Begin Date

End Date

Section 7. Other Health Insurance

30. Do you or your spouse have health insurance? ☐ Yes ☐ No

— If **yes**, please provide the following information:

1.

Person Insured

Name of Insurance Company

Policy ID Number

Begin Date

End Date

Type of Coverage:

☐ Hospital

☐ Mental Health

☐ Doctor

☐ Vision

☐ Medicine

☐ Medicare Extended

☐ Dental

☐ Other: _____

2.

Person Insured

Name of Insurance Company

Policy ID Number

Begin Date

End Date

Type of Coverage:

Check all that apply

☐ Hospital

☐ Mental Health

☐ Doctor

☐ Vision

☐ Medicine

☐ Medicare Extended

☐ Dental

☐ Other: _____

Section 8. State and Local Hospitalization (SLH)

Complete this section if you or anyone for whom you are applying received or will receive inpatient or outpatient services at a hospital or health department clinic.

31. Have you received these services within the last 30 days or are you scheduled to receive inpatient or outpatient hospitalization services or services at a health department clinic? ☐ Yes ☐ No

— If **yes**, please provide the following information:

Person Receiving Services

Name of Hospital or Clinic

Date Admitted/Scheduled

Date Discharged

Section 9. Your Rights and Responsibilities

Read this section before signing the application

Reporting Changes

Remember that you must report the following changes for Medical Assistance Programs within 10 days:

- Change of physical address or mailing address.
- Change in the persons in the household — person left, person born, etc.
- Change in source of income, getting a new job, stopping a job, other benefits, etc.
- Change in rate of pay per hour/day, or number of hours worked per pay period.
- Change in the amount of monthly income received that is not from working.
- Change in resources, such as receiving or giving away a resource or resources exceeding the limits.
- Change in motor vehicles owned.
- Change in marital status.
- Person in home is no longer disabled.
- Other changes that may affect eligibility for a program or the type of coverage or amount of assistance.

If you are not sure whether to report a particular change, please discuss the change with your worker.

Additional Responsibilities

- I understand that Medicaid, and DMAS contractors may exchange information relating to my coverage with local agencies, to assist with application, enrollment, administration, and billing services.
- I understand that to receive benefits from the Medicaid program, I must agree to assign my rights and the rights of anyone for whom I am applying to medical support and other third-party payments to the Department of Medical Assistance Services. If I do not agree to assign my rights, I will be ineligible for Medicaid.
- I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219.
- I understand that my signature on this application certifies, under penalty of perjury, that I am (unless applying for emergency services only) a U.S. citizen or alien in lawful immigration status.
- I understand that I have the right to file a complaint if I believe I have been discriminated against because of race, color, national origin, sex, age, disability, or religious or political beliefs.
- I understand that I must report ownership of all annuities my spouse and I have. I also understand that my spouse and I may have to name the Commonwealth of Virginia as the beneficiary on any annuity we may have in order for Medicaid to pay for long-term care services.
- I understand that I am authorizing the Department of Social Services to obtain verification/information necessary to determine my eligibility for Medical Assistance.

Appeal Rights

You have the right to request an appeal and to have a fair hearing of any action that affects eligibility for Medical Assistance. This includes the right to a timely decision made on this application, and timely notice of the decision in writing. The request for an appeal must be in writing.

By My Signature...

I declare that I fully understand this application for assistance and agree to the rights and responsibilities as described. I declare that I have given complete, accurate, and truthful information. I understand that if the information I give now or in the future is false, incorrect, or incomplete, or if I do not report changes as required, I will be breaking the law and could be prosecuted for perjury, larceny, or fraud.

Signature or Mark of Applicant

Date

Signature or Mark of Spouse, if Also Applying

Date

I completed this application myself.

☐ Yes ☐ No

I did not complete this application, but someone read it back to me when it was completed.

☐ Yes ☐ No

Witness to Mark, or Interpreter

Date

Signature of Worker

Date

Complete if applicant did not fill out the application.

<hr/> Name of Person Who Filled Out This Application	<hr/> Date
<hr/> Address (Street, PO Box, etc.)	<hr/> City, State, ZIP
<hr/> Telephone	<hr/> Relationship to Applicant